

WELCOME TO PERFORMANCE FOOTCARE OF NEW YORK, PC

Thank you for selecting our podiatric care team. We will strive to provide you with the best possible foot care. To help us meet all of your foot care needs, please fill out this form COMPLETELY. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT INFORMATION AND HISTORY PLEASE PRINT

PATIENT NAME _____ () _____
FIRST LAST M.I.

BIRTHDAY: ____ / ____ / ____ MAR/SING/DEV/WID MALE/FEMALE

PHONE:(H) _____ (W) _____ CELL: _____ EMAIL: _____

HOME ADDRESS: NO. & STREET: _____ CITY: _____ ST: _____ ZIP _____

EMPLOYER _____ OCCUPATION _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____ RELATIONSHIP _____

EMERGENCY CONTACT: _____ PHONE: _____ RELATIONSHIP _____

Are you covered under health insurance benefits sponsored by your employer? YES NO

Are you covered under health insurance benefits sponsored by your spouse or parent's employer? YES NO

Primary Insurance Company: _____ Additional Insurance Company: _____

Name of Insured: _____ Name of Insured: _____

Relationship of Patient: ____ Self ____ Spouse ____ Parent Relationship to Patient: ____ Self ____ Spouse ____ Parent

Birth Date of Insured: _____ Birth Date of Insured: _____

Group # _____ ID# _____ Group # _____ ID# _____

What is your Primary reason for today's visit (body part(s) and brief description of problem including side): _____

If pain is the major component of the primary problem:

What kind of pain is it? Burning/Throbbing/Achy/Sharp/Dull/Other: _____

When at rest, rate of pain from 0-10 (0=no pain, 10=worst pain of your life): _____

What activity worsens the pain? _____

What helps relieve the pain? _____

When doing these activities, rate the pain 0-10: _____

DATE PROBLEM STARTED: _____ Work related? Yes/No Car accident? Yes/No

How did the problem start/occur? _____

Have you had prior imaging studies (X-ray, MRI, CAT Scan) done for this problem? Yes/No

If YES, list type of study and location, and date: _____

Have you been seen and/or treated by anyone else for this problem/injury? Yes/No

If YES, then by whom? _____ Date(s): _____

Treatment performed: _____

Have you had Physical Therapy for this problem? Yes/No

If YES, when and for how long? _____

(Continued on back)

REVIEW OF SYSTEMS

Do you have any problems with, or have you noticed any change in the following areas? If yes, please check what applies.

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Asthma	<input type="checkbox"/> Breast Masses	<input type="checkbox"/> Enlarged Lymph Nodes	<input type="checkbox"/> Sprain
<input type="checkbox"/> Palpitation	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Balance Problems	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Irregular Heart Beats	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Seizures	<input type="checkbox"/> Malaise	<input type="checkbox"/> Stiffness
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Fever	<input type="checkbox"/> Weakness
<input type="checkbox"/> Anemia	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Depression	<input type="checkbox"/> Atrophy	<input type="checkbox"/> Numbness
<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Urinary Hesitancy	<input type="checkbox"/> Incoordination	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Cough	<input type="checkbox"/> Burning Urination	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Bloody Sputum	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Skin Rashes	<input type="checkbox"/> Constipation
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Pregnancies	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Fracture	

If YES to any of the above, please explain: _____

If there is anything pertinent in your health that was not mentioned above, please explain: _____

MEDICAL HISTORY

Please circle none when indicated.

Medical problems: _____ NONE

Are you currently taking any medications (including vitamins and supplements)? Yes/No

If yes, please list: _____

Drug Allergies: PENICILLIN/NOVOCAINE/CODEINE/ASPIRIN/TAPE.IODINE/OTHER: _____ NONE

Other Allergies: (Including shellfish, latex, IV, dye, etc.): _____

Previous Surgery (please give dates if possible): _____

List relationship to you of family members who have had:

Diabetes _____	Foot problems _____
Arthritis _____	Heart Attack _____
Stroke _____	High Blood Pressure _____
Cancer _____	Birth Defects _____

SOCIAL HISTORY

Occupation _____ Are you currently working? Yes/No/Student

What hobbies do you participate in? _____

Do you drink alcoholic beverages? Yes/No If so, how much? _____

Do you smoke? Yes/No If yes, how much? _____ How many years? _____

If you quit smoking, when did you do so? _____

Do you use any drugs for nonmedical purposes? Yes/No If Yes, what type? _____

Are you or could you be pregnant? Yes/No

How did you learn about our practice?

Performance Foot care website/Insurance Website/Google/Zocdoc/Patient (who?) _____ Other _____

Signature of Patient: X _____ Date: _____

For minors if you are Parent or Guardian X _____ Date: _____

I have reviewed this form (Dr.Butts/Dr.Debello): X _____ Date: _____

PERFORMANCE FOOTCARE OF NEW YORK, P.C.
36 WEST 44TH ST, SUITE 1216
NEW YORK, NY 10036
OFFICE: (212) 768-0012
FAX: (212) 354-1929

AUTHORIZATION FOR USE OF SIGNATURE
ON FILE FOR CLAIM AUTHORIZATION

I, _____ authorize Dr. Bryon Butts / Dr. John Debello to mark the
Enrollee Name Provider Name (Doctor)

“ENROLLEE’S OR AUTHORIZED PERSON SIGNATURE” with the notation “SIGNATURE ON FILE”.

This section authorizes the following:

1. The release of any medical information necessary to process this claim
2. Payment of medical benefits to the undersigned physician or supplier of the services described below.

This authorization will remain in force until terminated in writing by the enrollee.

Enrollee Signature Date

**AGREEMENT FOR DOCTOR TO RECEIVE INSURANCE CHECKS MAILED TO YOU BY YOUR
INSURANCE COMPANY FOR SERVICES YOU RECEIVED HERE.**

I, _____ realize that I may receive checks from my insurance carrier for services that are provided in this office. I understand that it is my responsibility to sign the back of those checks and forward them, along with the Explanation of Benefits (EOB) that is attached to the check and all corresponding pages, to the above office within 7 days. If I fail to do so, I will be responsible for the full amount of the bill plus any interest and legal fees incurred for collecting them.

Patient Signature Date

**PLEASE NOTE THAT WE HAVE A 24 HOUR CANCELLATION POLICY. NO SHOWS
AND LATE CANCELLATIONS WILL BE CHARGED \$25!**

PERFORMANCE FOOT CARE OF NEW YORK, P.C.

36 WEST 44TH ST, SUITE 1216

NEW YORK, NY 10036

PHONE: (212) 768-0012

FAX: (212) 768-0168

**ACKNOWLEDGMENT OF RECEIPT
OF
CONFIDENTIALITY POLICY**

I have received a paper copy of the confidentiality policy, as required by HIPPA of 1996.

Patient Signature: _____ Date: _____

Print Name: _____

CONTACT DETAILS

I give Performance foot care staff members permission to contact me by

Cell phone: _____

Work/ Home: _____

Email: _____

In Regards to my appointment and other matters.

Signature

CANCELLATION POLICY

It is our company's policy that appointment cancellations within 24 hours prior to your scheduled appointment without a rescheduled date will incur a charge of twenty five dollars.

I have read and understand that I will be subject to pay the late \$25 cancellation fee, for first time occurrence the fee will be waived after which the fee will be in effect.

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CONFIDENTIALITY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dr. Bryon Butts at Performance Footcare of New York P.C. is committed to maintaining the confidentiality of his patient's protected health information (PHI). We, at Performance Footcare of New York, emphasize the importance of confidentiality through employee training, the implementation of procedures designed to protect the security of our records, and our privacy policy. We restrict access to PHI to those employees who need to know that information to perform her/his job responsibilities. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard confidentiality of PHI.

Consent obtained during the admission process to the Center covers use and disclosure of PHI for purposes of treatment, payment, and healthcare operations, including quality assessment and measurement, and disease management activities. Before any PHI is disclosed for purposes of treatment, payment, or healthcare operations, agreement with the recipients of such information are entered into the protection of the confidentiality of PHI. If the patient is unable to give consent, family or legally appointed representatives will be authorized to release and/or receive access to information about the patient.

Business Associates: A business is an individual or entity under construct with us to perform or assist us in a function or activity which necessitates the use of medical information. For example: a medical record copy service, consultants, accountants, lawyers, medical transcription and third party billing companies. We require Business Associates to submit a written statement as to how they will protect the confidentiality and dispose of PHI when use has been completed.

Federal law provides that we may use your PHI without further specific notice to you or written authorization by you in the following categories:

For your treatment: In diagnosing and treating your injury or illness, we may disclose any portion of your PHI to attending physicians, consulting physicians, nurses, technicians, medical students, interns, residency programs, continuing education training, to a home health agency or hospital to coordinate specific services, such as prescriptions, lab work, x-rays, and to other health care providers who had a legitimate need for such information in your care and continued treatment.

To obtain payment: We may use and disclose your medical information so that the service and treatment may be billed to, and payment may be collected from your health insurer, HMO, or other company that arranges or pays the cost of your healthcare.

For health care operations: We may use and disclose your medical information for internal administration and planning to improve the quality and cost effectiveness of the care that we deliver to you, for example: Performance improvement, utilization review, internal auditing, accreditation, certification, licensing, education and credentialing activities. We may remove information that identifies you from this set of medical information so others may use it to study healthcare and healthcare delivery without learning your identity.

We may use or disclose medical information without further notice to you, or specific authorization by you, where:

1. Required by law.
2. Required for public health purposes.
3. Required by law to report child abuse and neglect.
4. Required by health oversight agencies for oversight activities authorized by law, such as the Department of Health, Office of Professional Medical Conduct.
5. Required to report information about products under the jurisdiction of the Federal Drug Administration.
6. Required by law for judicial or administrative proceeding.
7. Required by law for enforcement purposes by a law enforcement official.

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DRB@PERFORMANCEFOOTCARENYC.COM

Dear patient:

For the convenience of all of our patients, we have simplified our payment policy.
COPAYMENT IS REQUESTED AT THE TIME OF YOUR VISIT.

Please choose from the following options:

- _____ Payment by cash
_____ Payment by check
_____ Payment by credit card

_____ (PLEASE INITIAL) **I understand that insurance may cover all or a portion of my treatment(s). My credit card will not be charged more than the amount allowed by my insurance company.**

Please make your choice, sign below and return to the office manager before treatment.
Our office is a fully approved and accredited user of the Visa and Mastercard Healthcare Program which will enable you to use your credit card to automatically cover amounts not paid by your insurance.

If none of the above apply, please see the office manager. Thank you.

Print Patient/ Guardian name

Patient / Guardian Signature

Date: ____/____/____